

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Duley		NMN		Burton				12		12		83		1a:30		M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 MRS							
MALE		BLACK		JUNE 30, 1908		75		MONTHS		DAYS		HOURS		MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
MD.		U.S.A				Kent MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
Chestertown		The Kent & Queen Anne's Hospital, INC. LAUREL															
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
MD		Kent		Chestertown		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		349		CANNON ST							
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST						FIRST MIDDLE LAST											
John NMN Burton																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)						16b. SOCIAL SECURITY NO.						17. INFORMANT - ADDRESS					
NO						207-03-2731						MRS. Helen Jackson Chestertown, PA. 1107 PARKER					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
4860 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.	DUE TO, OR AS A CONSEQUENCE OF (b) <u>Shock, Cause undetermined.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Pneumonia, Bil. Peritular</u>	

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY <table border="1"> <tr> <td>HOUR</td> <td>A.M.</td> <td>MONTH</td> <td>DAY</td> <td>YEAR</td> </tr> <tr> <td></td> <td>P.M.</td> <td></td> <td></td> <td>19</td> </tr> </table>	HOUR	A.M.	MONTH	DAY	YEAR		P.M.			19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2)
HOUR	A.M.	MONTH	DAY	YEAR								
	P.M.			19								

MEDIC	21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET	CITY OR TOWN	COUNTY	STATE
	WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK					

22a. I certify that (I) (this hospital) attended the deceased from 12/12, 19 83, to 12/12, 19 83, that (I) (we) lost
saw the deceased alive on 12/12, 19 83, and that in my (our) opinion death occurred on the date and hour and from the causes stated
above. (I) (we) (did) (did not) view the body after death.

22b. SIGNATURE <i>H. Williams</i>	DEGREE <i>MD</i>	ATTENDING PHYSICIAN	<input checked="" type="checkbox"/> MEDICAL DIRECTOR	<input type="checkbox"/> STAFF PHYSICIAN	22c. DATE SIGNED <i>12/14/83</i>
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27a. PHYSICIAN'S NAME (TYPE OR PRINT)	27b. ADDRESS
KEN K. WILSON, MD.	216 High St. Chestertown, Md. 21620

23a. BURIAL, CREMATION, REMOVAL (SEE 23c)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION (CITY OR TOWN) COUNTY STATE
BURIAL	12-17-1983	ARBOR CHAPEL	ROCK HALL KENT MD
24. FUNERAL DIRECTOR	25a. DATE RECEIVED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE		

NAME Samuel H. Chastain ADDRESS 6666 16th Ave
DATE REC'D BY REGISTRATION JAN 5 1984 SIGNATURE for me J. Chastain

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP.

25 3000 ft. 2000 ft. 1000 ft. 500 ft. 250 ft. 125 ft. 62 ft. 31 ft. 15 ft. 7 ft. 3 ft. 1 ft. 1/2 ft. 1/4 ft. 1/8 ft. 1/16 ft. 1/32 ft. 1/64 ft. 1/128 ft. 1/256 ft. 1/512 ft. 1/1024 ft. 1/2048 ft. 1/4096 ft. 1/8192 ft. 1/16384 ft. 1/32768 ft. 1/65536 ft. 1/131072 ft. 1/262144 ft. 1/524288 ft. 1/1048576 ft. 1/2097152 ft. 1/4194304 ft. 1/8388608 ft. 1/16777216 ft. 1/33554432 ft. 1/67108864 ft. 1/134217728 ft. 1/268435456 ft. 1/536870912 ft. 1/1073741824 ft. 1/2147483648 ft. 1/4294967296 ft. 1/8589934592 ft. 1/17179869184 ft. 1/34359738368 ft. 1/68719476736 ft. 1/137438953472 ft. 1/274877906944 ft. 1/549755813888 ft. 1/1099511627776 ft. 1/2199023255552 ft. 1/4398046511104 ft. 1/8796093022208 ft. 1/17592186044416 ft. 1/35184372088832 ft. 1/70368744177664 ft. 1/140737488355328 ft. 1/281474976710656 ft. 1/562949953421312 ft. 1/1125899906842624 ft. 1/2251799813685248 ft. 1/4503599627370496 ft. 1/9007199254740992 ft. 1/18014398509481984 ft. 1/36028797018963968 ft. 1/72057594037927936 ft. 1/144115188075855872 ft. 1/288230376151711744 ft. 1/576460752303423488 ft. 1/1152921504606846976 ft. 1/2305843009213693952 ft. 1/4611686018427387904 ft. 1/9223372036854775808 ft. 1/18446744073709551616 ft. 1/36893488147419103232 ft. 1/73786976294838206464 ft. 1/147573952589676412928 ft. 1/295147905179352825856 ft. 1/590295810358705651712 ft. 1/1180591620717411303424 ft. 1/2361183241434822606848 ft. 1/4722366482869645213696 ft. 1/9444732965739290427392 ft. 1/18889465931478580854784 ft. 1/37778931862957161709568 ft. 1/75557863725914323419136 ft. 1/151115727451828646838272 ft. 1/302231454903657293676544 ft. 1/604462909807314587353088 ft. 1/1208925819614629174706176 ft. 1/2417851639229258349412352 ft. 1/4835703278458516698824704 ft. 1/9671406556917033397649408 ft. 1/19342813113834066795298816 ft. 1/38685626227668133590597632 ft. 1/77371252455336267181195264 ft. 1/154742504910672534362390528 ft. 1/309485009821345068724781056 ft. 1/618970019642690137449562112 ft. 1/1237940039285380274899124224 ft. 1/2475880078570760549798248448 ft. 1/4951760157141521099596496896 ft. 1/9903520314283042199192993792 ft. 1/19807040628566084398385987584 ft. 1/39614081257132168796771975168 ft. 1/79228162514264337593543950336 ft. 1/158456325028528675187087900672 ft. 1/316912650057057350374175801344 ft. 1/633825300114114700748351602688 ft. 1/1267650600228229401496703205376 ft. 1/2535301200456458802993406410752 ft. 1/5070602400912917605986812821504 ft. 1/10141204801825835211973625643008 ft. 1/20282409603651670423947251286016 ft. 1/40564819207303340847894502572032 ft. 1/81129638414606681695789005144064 ft. 1/162259276829213363391578010288128 ft. 1/324518553658426726783156020576256 ft. 1/649037107316853453566312041152512 ft. 1/1298074214633706907132624082305024 ft. 1/2596148429267413814265248164610048 ft. 1/5192296858534827628530496329220096 ft. 1/10384593717069655257060992658440192 ft. 1/20769187434139310514121985316880384 ft. 1/41538374868278621028243970633760768 ft. 1/83076749736557242056487941267521536 ft. 1/166153499473114484112975882535043072 ft. 1/332306998946228968225951765070086144 ft. 1/664613997892457936451903530140172288 ft. 1/1329227995784915872903807060280344576 ft. 1/2658455991569831745807614120560689152 ft. 1/5316911983139663491615228241121378304 ft. 1/10633823966279326983230456482242756608 ft. 1/21267647932558653966460912964485513216 ft. 1/42535295865117307932921825928971026432 ft. 1/85070591730234615865843651857942052864 ft. 1/170141183460469231731687303715884105728 ft. 1/340282366920938463463374607431768211456 ft. 1/680564733841876926926749214863536422912 ft. 1/1361129467683753853853498429727072845824 ft. 1/2722258935367507707706996859454145691648 ft. 1/5444517870735015415413993718908291383296 ft. 1/10889035741470030830827987437816582766592 ft. 1/21778071482940061661655974875633165533184 ft. 1/43556142965880123323311949751266331066368 ft. 1/87112285931760246646623899502532662132736 ft. 1/174224571863520493293247799005065324265472 ft. 1/348449143727040986586495598010130648530944 ft. 1/696898287454081973172991196020261297061888 ft. 1/1393796574908163946345982392040522594123776 ft. 1/2787593149816327892691964784081045188247552 ft. 1/5575186299632655785383929568162090376495104 ft. 1/11150372599265311570767859136324180752990208 ft. 1/22300745198530623141535718272648361505980416 ft. 1/44601490397061246283071436545296723011960832 ft. 1/89202980794122492566142873090593446023921664 ft. 1/178405961588244985132285746181186892047843328 ft. 1/356811923176489970264571492362373784095686656 ft. 1/713623846352979940529142984724747568191373312 ft. 1/1427247692705959881058285969449495136382746624 ft. 1/2854495385411919762116571938898990272765493248 ft. 1/5708990770823839524233143877797980545530986496 ft. 1/11417981541647679048466287755595961091061972992 ft. 1/22835963083295358096932575511191922182123945984 ft. 1/45671926166590716193865151022383844364247891968 ft. 1/91343852333181432387730302044767688728495783936 ft. 1/182687704666362864775460604089535377456991567872 ft. 1/365375409332725729550921208179070754913983135744 ft. 1/730750818665451459101842416358141509827966271488 ft. 1/1461501637330902918203684832716283019655932542976 ft. 1/2923003274661805836407369665432566039311865085952 ft. 1/5846006549323611672814739330865132078623730171904 ft. 1/11692013098647223345629478661730264157247460343808 ft. 1/23384026197294446691258957323460528314494920687616 ft. 1/46768052394588893382517914646921056628989841375232 ft. 1/93536104789177786765035829293842113257979682750464 ft. 1/187072209578355573530071658587684226515959365500928 ft. 1/374144419156711147060143317175368453031918731001856 ft. 1/748288838313422294120286634350736906063837462003712 ft. 1/1496577676626844588240573268701473812127674924007424 ft. 1/2993155353253689176481146537402947624255349848014848 ft. 1/5986310706507378352962293074805895248510699696029696 ft. 1/11972621413014756705924586149611790497021399392059392 ft. 1/23945242826029513411849172299223580994042798784118784 ft. 1/47890485652059026823698344598447161988085597568237568 ft. 1/95780971304118053647396689196894323976171195136475136 ft. 1/191561942608236107294793378393788647952342390272950272 ft. 1/383123885216472214589586756787577295904684780545900544 ft. 1/766247770432944429179173513575154591809369561091801088 ft. 1/1532495540865888858358347027150309183618739122183602176 ft. 1/3064991081731777716716694054300618367237478244367204352 ft. 1/6129982163463555433433388108601236734474956488734408704 ft. 1/12259964326927110866866776217202473468949912977468817408 ft. 1/24519928653854221733733552434404946937899825954937634816 ft. 1/49039857307708443467467104868809893875799651909875269632 ft. 1/98079714615416886934934209737619787751599303819750539264 ft. 1/196159429230833773869868419475239575503198607639501078528 ft. 1/392318858461667547739736838950479151006397215279002157056 ft. 1/784637716923335095479473677900958302012794430558004314112 ft. 1/1569275433846670190958947355801916604025588861116008628224 ft. 1/3138550867693340381917894711603833208051177722232017256448 ft. 1/6277101735386680763835789423207666416102355444464034512896 ft. 1/12554203470773361527671578846415332832204710888928069025792 ft. 1/25108406941546723055343157692830665664409421777856138051584 ft. 1/50216813883093446110686315385661331328818843555712276103168 ft. 1/100433627766186892221372630771322662657637687111424552206336 ft. 1/200867255532373784442745261542645325315275374222849104412672 ft. 1/401734511064747568885490523085290650630550748445698208825344 ft. 1/803469022129495137770981046170581301261101496891396417650688 ft. 1/1606938044258990275541962092341162602522202993782792835301376 ft. 1/3213876088517980551083924184682325205044405987565585670602752 ft. 1/6427752177035961102167848369364650410088811975131171341205504 ft. 1/12855504354071922204335696738729300820177623950262342682411008 ft. 1/25711008708143844408671393477458601640355247900524685364822016 ft. 1/51422017416287688817342786954917203280710495801049370729644032 ft. 1/102844034832575377634685573909834406561420991602098741459288064 ft. 1/205688069665150755269371147819668813122841983204197482918576128 ft. 1/411376139330301510538742295639337626245683966408394965837152256 ft. 1/822752278660603021077484591278675252491367932816789931674304512 ft. 1/1645504557321206042154969182557350504982735865633579863348609024 ft. 1/3291009114642412084309938365114701009965471731267159726697218048 ft. 1/6582018229284824168619876730229402019930943462534319453394436096 ft. 1/13164036458569648337239753460458804039861886925068638906788872192 ft. 1/26328072917139296674479506920917608079723773850137277813577744384 ft. 1/52656145834278593348959013841835216159447547700274555627155488768 ft. 1/105312291668557186697918027683670432318895095400549111254310977536 ft. 1/210624583337114373395836055367340864637790190801098222508621955072 ft. 1/421249166674228746791672110734681729275580381602196445017243910144 ft. 1/842498333348457493583344221469363458551160763204392890034487820288 ft. 1/1684996666796914987166688442938726917102321526408785780068975640576 ft. 1/3369993333593829974333376885877453834204643052817571560137951281152 ft. 1/6739986667187659948666753771754907668409286105635143120275902562304 ft. 1/13479973334375319897333507543509815336818572211270286240551805124608 ft. 1/26959946668750639794667015087019630673637144422540572481103610249216 ft. 1/53919893337501279589334030174039261347274288845081144962207220498432 ft. 1/107839786675002559178668060348078522694548577690162289924414440996864 ft. 1/215679573350005118357336120696157045389097155380324579848828881993728 ft. 1/431359146700010236714672241392314090778194310760649159697657763987456 ft. 1/862718293400020473429344482784628181556388621521298319395315527974912 ft. 1/1725436586800040946858688965569256363112777243042596638790631055949824 ft. 1/3450873173600081893717377931138512726225554486085193277581262111899648 ft. 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1/28269553038131870873332760011886696253239742350009903329945699220681916416 ft. 1/56539106076263741746665520023773392506479484700019806659891398441363832832 ft. 1/113078212152527483493331040047546785012958969400039613319782796882727665664 ft. 1/226156424305054966986662080095093570025917938800079226639565593765455331328 ft. 1/452312848610109933973324160190187140051835877600158453279131187530910662656 ft. 1/904625697220219867946648320380374280103671755200316906558262375061821325312 ft. 1/1809251394440439735893296640760748560207343510400633813116524750123642650624 ft. 1/3618502788880879471786593281521497120414687020801267626233049500247285301248 ft. 1/7237005577761758943573186563042994240829374041602535252466099000494570602496 ft. 1/14474011155523517887146373126085988481658748083205070504932198000989141204992 ft. 1/28948022311047035774292746252171976963317496166410141009864396001978282409984 ft. 1/57896044622094071548585492504343953926634992332820282019728792003956564819968 ft. 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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ivy Myrtle Campbell			2a. DATE OF DEATH MONTH DAY YEAR 12-23-83		2b. HOUR 5:09 pm		
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Jan. 31, 1910		6. AGE (IN YEARS (LAST BIRTHDAY)) 73	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN RFD Worton		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Henry J. Plant		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Brodgen		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216 40 4838	
17. INFORMANT Charles Campbell		ADDRESS RFD Wymont Park Worton, Md.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Carcinoma of the Ovary</u> <u>1830</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3-4 months</u>	

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) this hospital attended the deceased from <u>September 23, 1983</u> , to <u>Dec 23, 1983</u> , that (1) we last saw the deceased alive on <u>Dec 23, 1983</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. <u>(I/we) did not</u> view the body after death.							
22b. SIGNATURE <u>Charles P. Adams</u>		DEGREE <u>M.D.</u>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Dec. 26, 1983</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Charles P. Adams</u>		M.D.		22e. ADDRESS <u>Chestertown, Maryland.</u>			

23a. BURIAL, CREMATION, REMOVAL (SICRITY) Burial		23b. DATE 12/26/83		23c. NAME OF CEMETERY OR CREMATORY Galena Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Galena, Md.	
24. FUNERAL DIRECTOR NAME <u>James Wells</u>				25a. DATE REC'D. BY REGISTRAR DEC 29 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Smith</u>	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Registrar of the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP_____

DHMH - 17
(VR A15 ME (5))
15M 2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Virginia Cann												2a. DATE KNOWN OF DEATH ESTI- MATED 12/15 1983		2b. HOUR 6:00	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Feb 28 1925		6. AGE (IN YEARS) LAST BIRTHDAY 58 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Dec 15, 1983		2d. HOUR 11:30	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.			
10. CITY OR TOWN OF DEATH Chestertown				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 421 Calvert Street 21620					
14. FATHER'S NAME FIRST MIDDLE LAST James Fulton								15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marion Floyd							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-14-2506				17. INFORMANT ADDRESS Mrs. Kim Freeman Chestertown, Md.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .															
ACTUAL SIGNATURE Robert W. Farr				M.D. (SPECIFY) Robert W. Farr				MEDICAL EXAMINER DATE SIGNED 12/16/83							
EXAMINER'S NAME (TYPE OR PRINT) Robert W. Farr M.D.				ADDRESS Chestertown, Maryland											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 12/20/83		23c. NAME OF CEMETERY OR CREMATORY Janes Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown Kent Md.					
24. FUNERAL DIRECTOR NAME J. J. J. J.				ADDRESS Chestertown, Maryland				25a. DATE REC'D. BY REGISTRAR DEC 20 1983				25b. REGISTRAR'S SIGNATURE John J. J. J.			



NOT COPY

15 JUL 1953

BY MAIL

RECEIVED

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 7 DAYS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M2/80

FOR STATE REGISTRAR		CLOTHIER		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 3 3 5 1 8			
1. DECEASED NAME (TYPE OR PRINT) William O CLOTHIER				2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 12/30/83 10:00 AM				2b. DATE PRONOUNCED DEAD Dec. 30, 1983 10:00 AM			
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 5/15/1918		6. AGE (IN YEARS) LAST BIRTHDAY 65 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
10. CITY OR TOWN OF DEATH Rock Hall				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Gen. Del. at home Rock Hall, Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Construction			
13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21661 cor Main & Sharp Sts.	
14. FATHER'S NAME FIRST MIDDLE LAST William H. Clothier						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Middleton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. WW 2 220 01 9885		17. INFORMANT RFD # 4 Bx 303 F2 Douglas Clothier Chestertown, Md.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> 5739 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) <u>History of treatment, Elsmere V.A. Hospital</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>per liver disease and alcoholism</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a.											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Robert W. Farr				TITLE (SPECIFY) M.D. Agent				DATE SIGNED 12/30/83			
EXAMINER'S NAME (TYPE OR PRINT) Kent County				ADDRESS Chestertown, Md.				21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 1/3/1984		23c. NAME OF CEMETERY OR CREMATORY Wesley Chapel Cem,				23d. LOCATION CITY OR TOWN COUNTY STATE Rock Hall, Md.	
24. FUNERAL DIRECTOR NAME William W. Williams ADDRESS Chestertown, Md.						25a. DATE REC'D. BY REGISTRAR 'JAN 4 1984		25b. REGISTRAR'S SIGNATURE John J. Canine			



Handwritten notes at the top of the page, including the word "RECEIVED" and some illegible scribbles.

Several lines of handwritten text in the middle section of the page, appearing to be a list or set of instructions.

Handwritten notes in the lower middle section, including a large 'X' mark and some illegible text.

Handwritten notes at the bottom of the page, including the word "RECEIVED" and some illegible scribbles.

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
		Charles Pearce Coady Jr.		12 19 83		11:05 PM	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct 31, 1901		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Lawyer		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Pearce Coady (Sr.)		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Millie Kenly		13e. STREET ADDRESS Byford Court		21620	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) IF YES, GIVE WAR OR DATES NO		16b. SOCIAL SECURITY NO. 218 14 1588		17. INFORMANT ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive heart failure 4157 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Pulmonary emboli DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 8 days 10 days							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a. Adenocarcinoma of Esophagus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 1-27, 19 83, to 12-19, 19 83, that (1) (me) lost saw the deceased alive on 12-19, 19 83, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (me) (did not) view the body after death.							
22b. SIGNATURE Wayne P. Benjamin		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-20-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wayne P. Benjamin M.D.		22e. ADDRESS Chestertown, Md 21620					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE 12/21/83		23c. NAME OF CEMETERY OR CREMATORY St. Paul's Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE near Chestertown, Md.	
24. FUNERAL DIRECTOR NAME J. Willis Wells		ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 22 1983		25b. REGISTRAR'S SIGNATURE J. Willis Wells	

BP

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Mildred Elizabeth Holden			2a. DATE OF DEATH MONTH DAY YEAR 12-28-83		2b. HOUR 8:37 P							
3. SEX Female		4. RACE CAUC		5. DATE OF BIRTH MONTH DAY YEAR 5-18-11		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.						
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Annes Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bookkeeper		12b. KIND OF BUSINESS OR INDUSTRY Plumbing				
13a. STATE MD			13b. COUNTY QA		13c. CITY OR TOWN Bridersville		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS Box 11 21666			
14. FATHER'S NAME FIRST MIDDLE LAST JAMES Rayfield JARRELL			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY EMMA HARRINGTON									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-03-1178			17. INFORMANT PAT Kimble			ADDRESS BOX 8 BARCLAY MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Heart block</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute myocardial infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>ASCVD & CAD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>22 hours</u>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)												
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <u>12-27</u> , 19 <u>83</u> , to <u>12-28</u> , 19 <u>83</u> , that (I) (we) last saw the deceased alive on <u>12-28-83</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <u>Harry P Ross</u>						DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <u>12-30-83</u>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HARRY P ROSS						22e. ADDRESS Chestertown MD 21620						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 12-31-83		23c. NAME OF CEMETERY OR CREMATORY Chesterfield Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Centreville QA MD				
24. FUNERAL DIRECTOR (NAME) Fellows F.H.						25a. DATE REC'D. BY REGISTRAR 2-18-84			25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers, Pages 1 and 2 and 7 and 8 and 9 and 10 and 11 and 12 and 13 and 14 and 15 and 16 and 17 and 18 and 19 and 20 and 21 and 22 and 23 and 24 and 25 and 26 and 27 and 28 and 29 and 30 and 31 and 32 and 33 and 34 and 35 and 36 and 37 and 38 and 39 and 40 and 41 and 42 and 43 and 44 and 45 and 46 and 47 and 48 and 49 and 50 and 51 and 52 and 53 and 54 and 55 and 56 and 57 and 58 and 59 and 60 and 61 and 62 and 63 and 64 and 65 and 66 and 67 and 68 and 69 and 70 and 71 and 72 and 73 and 74 and 75 and 76 and 77 and 78 and 79 and 80 and 81 and 82 and 83 and 84 and 85 and 86 and 87 and 88 and 89 and 90 and 91 and 92 and 93 and 94 and 95 and 96 and 97 and 98 and 99 and 100 and 101 and 102 and 103 and 104 and 105 and 106 and 107 and 108 and 109 and 110 and 111 and 112 and 113 and 114 and 115 and 116 and 117 and 118 and 119 and 120 and 121 and 122 and 123 and 124 and 125 and 126 and 127 and 128 and 129 and 130 and 131 and 132 and 133 and 134 and 135 and 136 and 137 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and 263 and 264 and 265 and 266 and 267 and 268 and 269 and 270 and 271 and 272 and 273 and 274 and 275 and 276 and 277 and 278 and 279 and 280 and 281 and 282 and 283 and 284 and 285 and 286 and 287 and 288 and 289 and 290 and 291 and 292 and 293 and 294 and 295 and 296 and 297 and 298 and 299 and 300 and 301 and 302 and 303 and 304 and 305 and 306 and 307 and 308 and 309 and 310 and 311 and 312 and 313 and 314 and 315 and 316 and 317 and 318 and 319 and 320 and 321 and 322 and 323 and 324 and 325 and 326 and 327 and 328 and 329 and 330 and 331 and 332 and 333 and 334 and 335 and 336 and 337 and 338 and 339 and 340 and 341 and 342 and 343 and 344 and 345 and 346 and 347 and 348 and 349 and 350 and 351 and 352 and 353 and 354 and 355 and 356 and 357 and 358 and 359 and 360 and 361 and 362 and 363 and 364 and 365 and 366 and 367 and 368 and 369 and 370 and 371 and 372 and 373 and 374 and 375 and 376 and 377 and 378 and 379 and 380 and 381 and 382 and 383 and 384 and 385 and 386 and 387 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and 638 and 639 and 640 and 641 and 642 and 643 and 644 and 645 and 646 and 647 and 648 and 649 and 650 and 651 and 652 and 653 and 654 and 655 and 656 and 657 and 658 and 659 and 660 and 661 and 662 and 663 and 664 and 665 and 666 and 667 and 668 and 669 and 670 and 671 and 672 and 673 and 674 and 675 and 676 and 677 and 678 and 679 and 680 and 681 and 682 and 683 and 684 and 685 and 686 and 687 and 688 and 689 and 690 and 691 and 692 and 693 and 694 and 695 and 696 and 697 and 698 and 699 and 700 and 701 and 702 and 703 and 704 and 705 and 706 and 707 and 708 and 709 and 710 and 711 and 712 and 713 and 714 and 715 and 716 and 717 and 718 and 719 and 720 and 721 and 722 and 723 and 724 and 725 and 726 and 727 and 728 and 729 and 730 and 731 and 732 and 733 and 734 and 735 and 736 and 737 and 738 and 739 and 740 and 741 and 742 and 743 and 744 and 745 and 746 and 747 and 748 and 749 and 750 and 751 and 752 and 753 and 754 and 755 and 756 and 757 and 758 and 759 and 760 and 761 and 762 and 763 and 764 and 765 and 766 and 767 and 768 and 769 and 770 and 771 and 772 and 773 and 774 and 775 and 776 and 777 and 778 and 779 and 780 and 781 and 782 and 783 and 784 and 785 and 786 and 787 and 788 and 789 and 790 and 791 and 792 and 793 and 794 and 795 and 796 and 797 and 798 and 799 and 800 and 801 and 802 and 803 and 804 and 805 and 806 and 807 and 808 and 809 and 810 and 811 and 812 and 813 and 814 and 815 and 816 and 817 and 818 and 819 and 820 and 821 and 822 and 823 and 824 and 825 and 826 and 827 and 828 and 829 and 830 and 831 and 832 and 833 and 834 and 835 and 836 and 837 and 838 and 839 and 840 and 841 and 842 and 843 and 844 and 845 and 846 and 847 and 848 and 849 and 850 and 851 and 852 and 853 and 854 and 855 and 856 and 857 and 858 and 859 and 860 and 861 and 862 and 863 and 864 and 865 and 866 and 867 and 868 and 869 and 870 and 871 and 872 and 873 and 874 and 875 and 876 and 877 and 878 and 879 and 880 and 881 and 882 and 883 and 884 and 885 and 886 and 887 and 888 and 889 and 890 and 891 and 892 and 893 and 894 and 895 and 896 and 897 and 898 and 899 and 900 and 901 and 902 and 903 and 904 and 905 and 906 and 907 and 908 and 909 and 910 and 911 and 912 and 913 and 914 and 915 and 916 and 917 and 918 and 919 and 920 and 921 and 922 and 923 and 924 and 925 and 926 and 927 and 928 and 929 and 930 and 931 and 932 and 933 and 934 and 935 and 936 and 937 and 938 and 939 and 940 and 941 and 942 and 943 and 944 and 945 and 946 and 947 and 948 and 949 and 950 and 951 and 952 and 953 and 954 and 955 and 956 and 957 and 958 and 959 and 960 and 961 and 962 and 963 and 964 and 965 and 966 and 967 and 968 and 969 and 970 and 971 and 972 and 973 and 974 and 975 and 976 and 977 and 978 and 979 and 980 and 981 and 982 and 983 and 984 and 985 and 986 and 987 and 988 and 989 and 990 and 991 and 992 and 993 and 994 and 995 and 996 and 997 and 998 and 999 and 1000.



1. The first part of the report is a summary of the work done during the year. It includes a list of the projects completed and a brief description of the results. The second part of the report is a detailed account of the work done on each project. It includes a description of the methods used, the results obtained, and a discussion of the significance of the work.

2. The third part of the report is a list of the publications and reports prepared during the year. It includes the title of each publication, the author's name, and the date of publication. The fourth part of the report is a list of the names of the persons who have contributed to the work during the year.

3. The fifth part of the report is a list of the names of the persons who have been employed during the year. It includes the name of each person, the position held, and the date of employment. The sixth part of the report is a list of the names of the persons who have been consulted during the year.

4. The seventh part of the report is a list of the names of the persons who have been interviewed during the year. It includes the name of each person, the position held, and the date of the interview. The eighth part of the report is a list of the names of the persons who have been interviewed during the year.

5. The ninth part of the report is a list of the names of the persons who have been interviewed during the year. It includes the name of each person, the position held, and the date of the interview. The tenth part of the report is a list of the names of the persons who have been interviewed during the year.

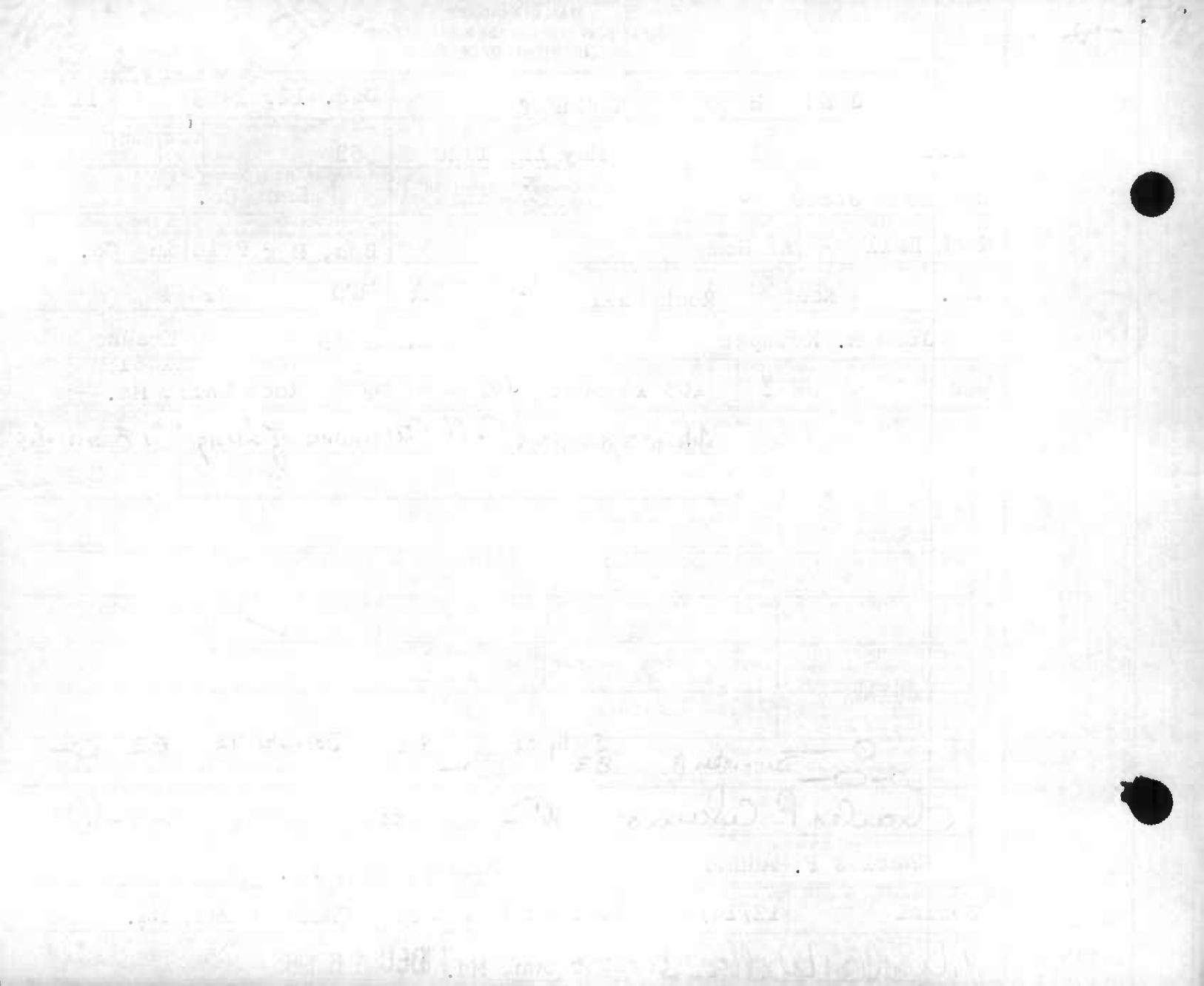
TO HOSPITAL, ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 16 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOHN H KRUMPET					2a. DATE OF DEATH Dec. 12, 1983			2b. HOUR 11 A M			
3 SEX Male		4 RACE white		5. DATE OF BIRTH May 11, 1920		6 AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		7 UNDER 1 YEAR MONTHS DAYS		7 UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York State		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent Co. MD.					
10 CITY OR TOWN OF DEATH Rock Hall		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bus. Mgr Printing Co.		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Rock Hall		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS RFD 21661			
14 FATHER'S NAME John A. Krumpet					15. MOTHER'S MAIDEN NAME Willamania Krause						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. WW 2 105 16 5048		17 INFORMANT Joyce Krumpet		ADDRESS Rock Hall, Md.					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Adenosquamous Cell Carcinoma of Lung 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 months	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from July 23, 1982 to December 13, 1983 , that (2) the deceased was (a) born on May 11, 1920 and that in (my) best opinion death occurred on the date and hour and from the causes stated above (1) was (did) not view the body after death.											
22b. SIGNATURE Charles P. Adamo						DEGREE MD		ATTENDING <input checked="" type="checkbox"/> MEDICAL <input type="checkbox"/> STAFF <input type="checkbox"/> PHYSICIAN DIRECTOR PHYSICIAN		22c. DATE SIGNED 12/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles P. Adamo						22e. ADDRESS Chestertown, Md.					
23a. BURIAL, CREMATION, REMOVAL Burial			23b. DATE 12/14/83		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.			
24 FUNERAL DIRECTOR NAME J. Wells Wells						ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE John J. Carver	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) Stein Amanda MULLIGAN			2a DATE OF DEATH MONTH DAY YEAR December 4, 1983			2b HOUR P 5:30				
3 SEX female		4 RACE white		5. DATE OF BIRTH MONTH DAY YEAR Oct. 8, 1895		6 AGE (IN YEARS LAST BIRTHDAY) YRS. 88		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Kent				
10 CITY OR TOWN OF DEATH Worton RFD		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) At Home Bx # 361				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.			13b COUNTY Kent		13c CITY OR TOWN Worton		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS 21678 RFD Worton Point	
14 FATHER'S NAME Will Edwards					15 MOTHER'S MAIDEN NAME Willie Smith Edwards					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no			16b SOCIAL SECURITY NO 219 34 2869		17 INFORMANT ADDRESS Va. M. Capel Worton, Md. 21678					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 A.S.C.U.D. DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9 years		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a I certify that (I) (the hospital) attended the deceased from Dec 1973 to 4 Dec 1983 , that (I) (we) lost saw the deceased alive on Oct 1983 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Harry Paul Ross					DEGREE MD ATTENDING <input checked="" type="checkbox"/> MEDICAL PHYSICIAN <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> DIRECTOR <input type="checkbox"/>			22c. DATE SIGNED 12/5/83		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Harry Paul Ross					22e. ADDRESS Chestertown, Md. 21620					
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 12/7/83		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md. 21620			
24 FUNERAL DIRECTOR NAME Willis Wells					ADDRESS 21620 Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 9 1983		25b. REGISTRAR'S SIGNATURE James J. Conrad	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BERTHA HACKETT NEWCOMB			2a. DATE OF DEATH MONTH DAY YEAR DEC 12 83			2b. HOUR 1:30 P.M.			
3. SEX F		4. RACE W.		5. DATE OF BIRTH MONTH DAY YEAR NOV 16 1898		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH KENT MD.			
10. CITY OR TOWN OF DEATH BETTERTON		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) L. WEBB NURSING FACILITY				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.		13b. COUNTY KENT		13c. CITY OR TOWN CHESTERTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 105 S WATER ST	
14. FATHER'S NAME FIRST MIDDLE LAST ANDREW JACKSON HACKETT		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VERINA RASIN		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 219-14-4558		17. INFORMANT ADDRESS MIRIAM N. JANNEY 105 S WATER ST. CHESTERTOWN, Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

4292

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) **arteriosclerotic C.V.D.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/12/83 , 19 83 , that (I) (we) last saw the deceased alive on 12/12/83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert W. Farr				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/12/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT W. FARR				22e. ADDRESS CHESTERTOWN, Md. 21620			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION		23b. DATE 12/13/83		23c. NAME OF CEMETERY OR CREMATORY SILVERBROOK CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE WILMINGTON N.C. Del.	
24. FUNERAL DIRECTOR NAME Marvin V. Williams Jr.				25. DATE REC'D BY REGISTRAR 19 1983			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM #M-3. RETAIN PAGE 5 AND 6 WITH THESE TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR 1- STATE REGISTRAR										DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO.														
1. DECEASED NAME (TYPE OR PRINT)					FIRST John Moore					MIDDLE Phipps					LAST					2a. DATE KNOWN OF DEATH		2b. DATE KNOWN OF DEATH		2c. DATE PRONOUNCED DEAD		2d. HOUR 8:33		2e. HOUR 8:33						
3. SEX Male		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 3 2 1910		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS.		7. DATE PRONOUNCED DEAD		8. MONTH DAY YEAR 12/24/83		9. BALTIMORE CITY OR COUNTY OF DEATH Kent		10. BALTIMORE CITY OR COUNTY OF DEATH Kent		11. BALTIMORE CITY OR COUNTY OF DEATH Kent		12. BALTIMORE CITY OR COUNTY OF DEATH Kent		13. BALTIMORE CITY OR COUNTY OF DEATH Kent		14. BALTIMORE CITY OR COUNTY OF DEATH Kent								
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia					7b. CITIZEN OF WHAT COUNTRY? U.S.A.					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Kent					10. BALTIMORE CITY OR COUNTY OF DEATH Kent		11. BALTIMORE CITY OR COUNTY OF DEATH Kent		12. BALTIMORE CITY OR COUNTY OF DEATH Kent		13. BALTIMORE CITY OR COUNTY OF DEATH Kent		14. BALTIMORE CITY OR COUNTY OF DEATH Kent						
11. CITY OR TOWN OF DEATH CHESTERTOWN					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) KENT & QUEEN ANNES HOSPITAL					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Insurance					12b. KIND OF BUSINESS OR INDUSTRY Insurance					13. BALTIMORE CITY OR COUNTY OF DEATH Kent		14. BALTIMORE CITY OR COUNTY OF DEATH Kent		15. BALTIMORE CITY OR COUNTY OF DEATH Kent		16. BALTIMORE CITY OR COUNTY OF DEATH Kent		17. BALTIMORE CITY OR COUNTY OF DEATH Kent		18. BALTIMORE CITY OR COUNTY OF DEATH Kent				
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Virginia					13b. COUNTY No County					13c. CITY OR TOWN Galax					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					13e. STREET ADDRESS Fries Road					14. BALTIMORE CITY OR COUNTY OF DEATH Kent		15. BALTIMORE CITY OR COUNTY OF DEATH Kent		16. BALTIMORE CITY OR COUNTY OF DEATH Kent		17. BALTIMORE CITY OR COUNTY OF DEATH Kent		18. BALTIMORE CITY OR COUNTY OF DEATH Kent	
14. FATHER'S NAME FIRST MIDDLE LAST John Catron Phipps					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ethel Lee Moore					16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No					16b. SOCIAL SECURITY NO. 231-32-9262					17. INFORMANT Priscilla P. Mertens-6815 Springfield Dr.					18. BALTIMORE CITY OR COUNTY OF DEATH Kent		19. BALTIMORE CITY OR COUNTY OF DEATH Kent		20. BALTIMORE CITY OR COUNTY OF DEATH Kent		21. BALTIMORE CITY OR COUNTY OF DEATH Kent		22. BALTIMORE CITY OR COUNTY OF DEATH Kent	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____																				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH														
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																																		
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?															20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>														
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE																								
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .																																		
ACTUAL SIGNATURE Robert W. Farr, M.D.					TITLE (SPECIFY) Deputy MEDICAL EXAMINER										DATE SIGNED 12/24/83																			
EXAMINER'S NAME (TYPE OR PRINT)					ADDRESS Chestertown, Kent County, Md. 21620																													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE Dec. 27, 1983					23c. NAME OF CEMETERY OR CREMATORY Felts Memorial Cem.					23d. LOCATION CITY OR TOWN COUNTY STATE Galax, VA 24333																			
24. FUNERAL DIRECTOR Thermon V. Williams Jr.					ADDRESS CHESTERTOWN, MD.					DATE RECEIVED BY REGISTRAR JAN 03 1984																								

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1 - FOR
STATE
REGISTRAR

PORTER

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lula Virginia Porter			2a. DATE OF DEATH MONTH DAY YEAR 12 22 83			2b. HOUR 3:55 A M	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Apr. 8, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker & Other	
13a. STATE Md.				13b. COUNTY Kent		13c. CITY OR TOWN Chestertown	
14. FATHER'S NAME FIRST MIDDLE LAST Charles Mench				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katherine Gyser			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219 03 0524		17. INFORMANT ADDRESS James Mench High St. 21620 Chestertown, Md.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Pump Failure
4100
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last

DUE TO, OR AS A CONSEQUENCE OF

(b)

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

11 days

4 days

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12-21</u> , 19 <u>83</u> , to <u>12-22</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12-21</u> , 19 <u>83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>A. C. Dick</u>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12-22-83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Dick				22e. ADDRESS Chestertown, Md. 21620			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/24/83		23c. NAME OF CEMETERY OR CREMATORY Chesterx Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME <u>J. Wilho Wells</u>				ADDRESS Chestertown, Md.		25a. DATE REC'D. BY REGISTRAR DEC 28 1983	
				25b. REGISTRAR'S SIGNATURE <u>James J. Lohr</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18, show any injury, or other traumatic event, the medical examiner must be notified by phone.

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

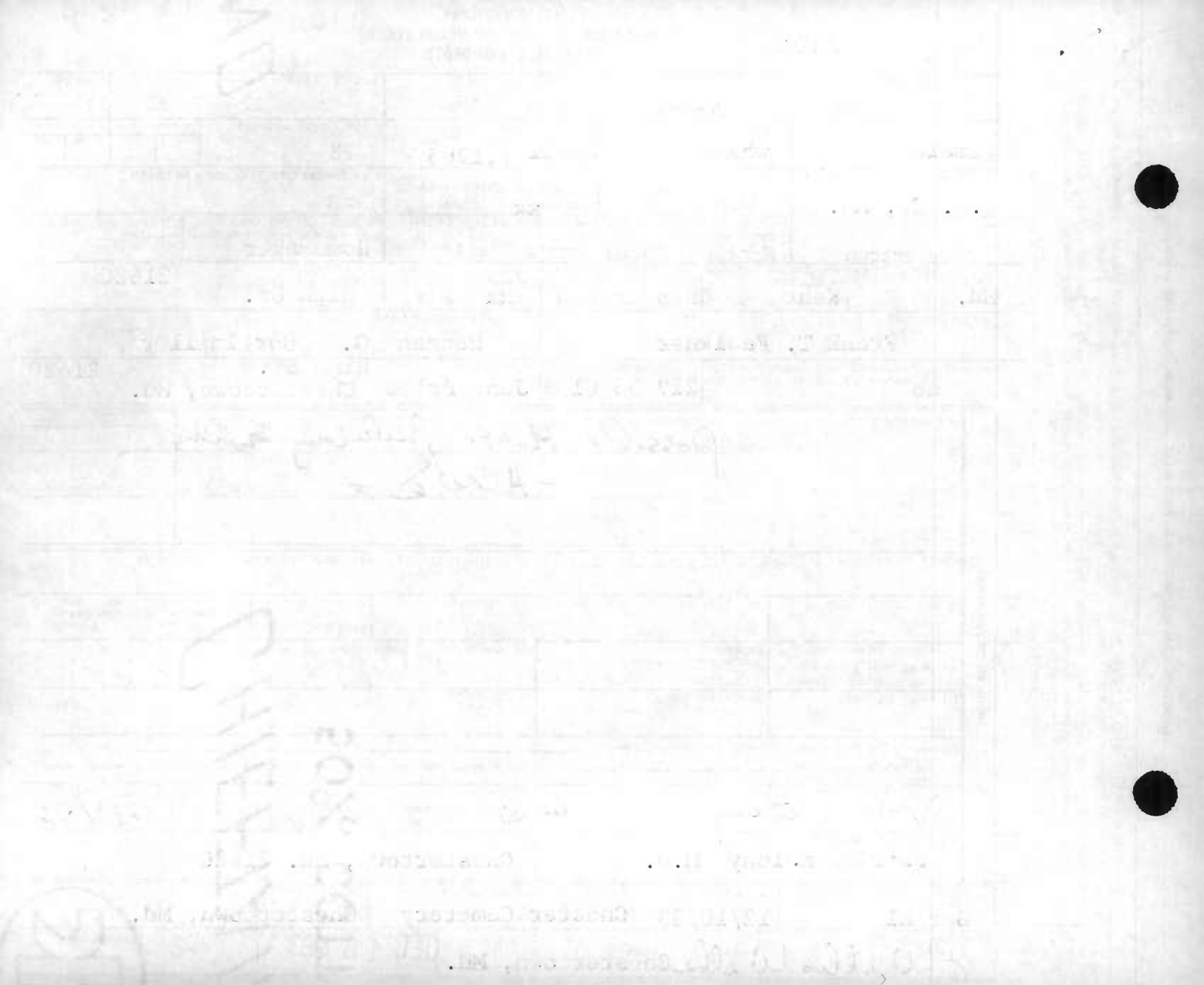
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR		PRICE		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) Mary Hannah Price				2a. DATE OF DEATH MONTH DAY YEAR 12 7 83		2b. HOUR A. M. 9:10	
3. SEX female		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR April 7, 1905		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) O.A. Co. Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent and Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md.		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS High St. 21620	
14. FATHER'S NAME FIRST MIDDLE LAST Frank T. Faulkner		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hannah G. Gortimiller		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 217 36 0158	
17. INFORMANT High St. 21620		17. INFORMANT Jane Price Chestertown, Md.		17. INFORMANT High St. 21620		17. INFORMANT Chestertown, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4292 DUE TO, OR AS A CONSEQUENCE OF (b) Possible Acute Pulmonary Embolism - ASCVD - Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c)						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Patrick Molony M.D.				DEGREE M.D.		22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patrick Molony M.D.				22e. ADDRESS Chestertown, Md. 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Chester Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Chestertown, Md.	
24. FUNERAL DIRECTOR NAME J. Willis Wells				24. FUNERAL DIRECTOR ADDRESS Chestertown, Md.			

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 - FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George Roy Skinner			2a. DATE OF DEATH MONTH DAY YEAR December 16, 1983			2b. HOUR 11:05 M	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 6 29 13		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER		12b. KIND OF BUSINESS OR INDUSTRY CONST.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Chestertown		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Roy WALTON SKINNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie WATLING					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-16-9802		17. INFORMANT MARGARET SKINNER WIFE SAME			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1541 DUE TO, OR AS A CONSEQUENCE OF (b) Exploratory laparotomy, ileostomy, lysis DUE TO, OR AS A CONSEQUENCE OF (c) CA rectum with widespread metastases 1 year		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 200 hours
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION 12-16-83		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Intestinal obstruction		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 11/10 1979 to 12/16 1983, that (I) (we) last saw the deceased alive on 12/16 1983, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature]		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/16/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. Robt. Schreiber		22e. ADDRESS MEDICAL BLDG CHESTERTOWN MD					

23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL		23b. DATE 12-18-83		23c. NAME OF CEMETERY OR CREMATORY CRUMPTON CEM		23d. LOCATION CITY OR TOWN COUNTY STATE CRUMPTON QA MD	
24. FUNERAL DIRECTOR NAME Fellows F.H.		ADDRESS Box 270 MILLINGTON MD		25a. DATE REC'D. BY REGISTRAR DEC 27 1983		25b. REGISTRAR'S SIGNATURE John J. Conner	

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. For use as a return to the funeral director, the certificate must be signed by the attending physician and completely filled in by the funeral director within 72 hours after death. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO THE DIRECTOR

FROM THE ASSISTANT

DATE

SUBJECT

RE

BY

FOR

BY

FOR

BY

FOR

BY

FOR

BY

FOR

RECEIVED

DATE

BY

FOR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST	
Herbert		Maurice		Smith		12-6-83 12:30A	
3. SEX MALE		4. RACE CAUC.		5. DATE OF BIRTH AUG. 27, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE (STATE OR FOREIGN) MASS.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital		12a. USUAL OCCUPATION (TYPE OF WORK, BUSINESS, OR SERVICE) (LIFE) BUILDER		12b. KIND OF BUSINESS OR INDUSTRY CONST.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND		13b. COUNTY KENT		13c. CITY OR TOWN MILLINGTON		13d. STREET ADDRESS Rt 1 BOX 258 21651	
14. FATHER'S NAME HERBERT J. SMITH		15. MOTHER'S MAIDEN NAME MARGARET CLEVERLY		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-20-3991	
17. INFORMANT MARGARET F. SMITH		ADDRESS wife same		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Astrocytoma Gr IV Biopsy proven</u> 1919 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mo.			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>12/4/83</u> , 19 <u>83</u> , to <u>12/5</u> , 19 <u>83</u> , that (I) (we) lost saw the deceased alive on <u>12/5/83</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>G. Baumann</u>		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/6/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) dr. gottfried baumann		22e. ADDRESS Meddical Building, Chestertown, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-9-83		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet		23d. LOCATION CITY OR TOWN COUNTY STATE WASHINGTON, DC	
24. FUNERAL DIRECTOR EDW. FELLOWS & SON MILLINGTON, MD 21651		25a. DATE REC'D. BY REGISTRAR DEC 16 1983		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

BP

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 72 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed in full by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. NAME: [REDACTED]
 2. ADDRESS: [REDACTED]
 3. CITY: [REDACTED]
 4. STATE: [REDACTED]
 5. ZIP: [REDACTED]
 6. PHONE: [REDACTED]
 7. FAX: [REDACTED]
 8. E-MAIL: [REDACTED]
 9. OCCUPATION: [REDACTED]
 10. EDUCATION: [REDACTED]
 11. MARITAL STATUS: [REDACTED]
 12. NUMBER OF CHILDREN: [REDACTED]
 13. DATE OF BIRTH: [REDACTED]
 14. DATE OF DEATH: [REDACTED]
 15. DATE OF INTERVIEW: [REDACTED]
 16. INTERVIEWER: [REDACTED]
 17. DATE OF REPORT: [REDACTED]
 18. REPORTER: [REDACTED]
 19. DATE OF REVIEW: [REDACTED]
 20. REVIEWER: [REDACTED]

21. DATE OF BIRTH: [REDACTED]
 22. DATE OF DEATH: [REDACTED]
 23. DATE OF INTERVIEW: [REDACTED]
 24. INTERVIEWER: [REDACTED]
 25. DATE OF REPORT: [REDACTED]
 26. REPORTER: [REDACTED]
 27. DATE OF REVIEW: [REDACTED]
 28. REVIEWER: [REDACTED]
 29. DATE OF BIRTH: [REDACTED]
 30. DATE OF DEATH: [REDACTED]
 31. DATE OF INTERVIEW: [REDACTED]
 32. INTERVIEWER: [REDACTED]
 33. DATE OF REPORT: [REDACTED]
 34. REPORTER: [REDACTED]
 35. DATE OF REVIEW: [REDACTED]
 36. REVIEWER: [REDACTED]
 37. DATE OF BIRTH: [REDACTED]
 38. DATE OF DEATH: [REDACTED]
 39. DATE OF INTERVIEW: [REDACTED]
 40. INTERVIEWER: [REDACTED]
 41. DATE OF REPORT: [REDACTED]
 42. REPORTER: [REDACTED]
 43. DATE OF REVIEW: [REDACTED]
 44. REVIEWER: [REDACTED]
 45. DATE OF BIRTH: [REDACTED]
 46. DATE OF DEATH: [REDACTED]
 47. DATE OF INTERVIEW: [REDACTED]
 48. INTERVIEWER: [REDACTED]
 49. DATE OF REPORT: [REDACTED]
 50. REPORTER: [REDACTED]
 51. DATE OF REVIEW: [REDACTED]
 52. REVIEWER: [REDACTED]
 53. DATE OF BIRTH: [REDACTED]
 54. DATE OF DEATH: [REDACTED]
 55. DATE OF INTERVIEW: [REDACTED]
 56. INTERVIEWER: [REDACTED]
 57. DATE OF REPORT: [REDACTED]
 58. REPORTER: [REDACTED]
 59. DATE OF REVIEW: [REDACTED]
 60. REVIEWER: [REDACTED]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove co-burial papers. Pages 1 and 2 should be filled with information with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medicolegal certificate must be notified at the

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO.			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR			
1. DECEASED NAME FIRST MIDDLE LAST Reginald Pleasant Stelfox				12/25/83			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR JANUARY 30, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) The Kent & Queen Anne's Hospital, Inc.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired-Police		12b. KIND OF BUSINESS OR INDUSTRY Balt. City	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN CATONSVILLE		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST EVERARD		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE (UNKNOWN)		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			
16b. SOCIAL SECURITY NO. 216-34-7899		17. INFORMANT ADDRESS FLORENCE L. KINSEY 304 LEE DRIVE BALTO. MD.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Heart Failure</u> 4151 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Anemia & G.I. Bleeding</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute Pulmonary Embolus</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>John D. Russell</i>				DEGREE M.D.		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 12-28-83		23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE MARYLAND	
24. FUNERAL DIRECTOR LEROY M. & RUSSELL C. WITZKE FUNERAL HOMES 1630 EDMONDSON AVENUE BALTO. MD. 21228				25a. DATE REC'D. BY REGISTRAR DEC 28 1983		25b. REGISTRAR'S SIGNATURE <i>John D. Russell</i>	

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE	LAST		
Naanie Kerr Strong		12		24	83		1:20 am
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
female	white	MONTH DAY YEAR		85		IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		USA				Kent MD.	
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Chestertown	The Kent & Queen Anne's Hospital			Inc. School teacher			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. INSIDE CITY LIMITS?		13c. STREET ADDRESS		13d. CITY OR TOWN	
Md. Kent		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21661		Rock Hall	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
Charles R. Kerr		Margaret Davis		no		219 36 7082	
17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Helen S. Kirkbride		Baltimore, Md.		IMMEDIATE CAUSE (a) <i>Acute Coronary Heart Failure</i>			
8011 York Rd.				2859 DUE TO, OR AS A CONSEQUENCE OF <i>ASCD</i>			
				DUE TO, OR AS A CONSEQUENCE OF <i>Arterial 2nd Gl Bleeding</i>			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>g</i>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <i>12/23</i> , 19 <i>83</i> , to <i>12/24/83</i> , 19 <i>83</i> , that (I) (we) last saw the deceased alive on <i>12/23</i> , 19 <i>83</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE		DEGREE		22c. DATE SIGNED			
<i>Patrick Molony</i>		M.D.		12/25/83			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		23a. BURIAL, CREMATION, REMOVAL		23b. DATE	
Patrick Molony		Chestertown, Md. 21620		Burial		12/27/83	
23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR	
St. Paul's Cem. near Chestertown, Md.				<i>William Wells</i>		DEC 29 1983	
				ADDRESS		25b. REGISTRAR'S SIGNATURE	
				Chestertown, Md.		<i>John J. Conner</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 3 3 3 5 3 1			
FOR 1. STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Elizabeth Lusby SUTTON				2a. DATE OF DEATH MONTH DAY YEAR Dec. 7, 1983			
3. SEX female				4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Aug 6, 1897	
6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS				7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Kent MD.	
10. CITY OR TOWN OF DEATH Chestertown		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Magnolia Hall Nursing Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker	
12b. KIND OF BUSINESS OR INDUSTRY		13. STREET ADDRESS 21667					
13a. STATE Md.		13b. COUNTY Kent		13c. CITY OR TOWN Still Pond		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST J. Zebulon Lusby				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gulielma Robinson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. 212 74 2682		17. INFORMANT ADDRESS Frances S. Legg Still Pond, Md.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ASCVD - Old age APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH several years							
DUE TO, OR AS A CONSEQUENCE OF (b)							
DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Old CVA							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/9 19 82 , to 12/7 19 83 , that (I) (we) last saw the deceased alive on 12/9 19 83 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE C. G. BAUMANN		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 12/8/83	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. G. BAUMANN				22e. ADDRESS CHESTERTOWN, MD 21620			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12/10/83		23c. NAME OF CEMETERY OR CREMATORY Shrewsbury Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Kennedyville, Md.	
24. FUNERAL DIRECTOR NAME J. Wilho Wells				ADDRESS Chestertown, Md.		25. DATE REC'D. BY REGISTRAR DEC 16 1983	
25. REGISTRAR'S SIGNATURE John J. Smith							

